Deconstructing the Hidden Curriculum of Dispassion and Proposing a Rhizomatic Model of Integrated Clinical Praxis

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ABSTRACT

Purpose: Biomedical education continues to transmit a hidden curriculum of clinical dispassion and reductionism that trains learners to treat bodies as machines and emotions as noise. This paper critiques that legacy and proposes a Rhizomatic Model of Clinical Praxis that integrates technical-scientific, ethical-interpretive, and relational-connective dimensions to cultivate "synaptic physicians" capable of humane, adaptive, and ethical practice in complexity.

Method: Using a critical theory lens, the analysis synthesizes medical education scholarship on the hidden curriculum and assessment, professional identity, narrative medicine, and interprofessional education with philosophy of medicine and power/knowledge analyses of the "clinical gaze," alongside contemporary evidence on empathy, burnout, and AI in medicine.

Results: The analysis identifies the hidden curriculum of dispassion as a structural impediment to humanistic care, professional identity formation, and patient trust, reinforced by language, role modeling, and assessments that valorize certainty and penalize uncertainty. The proposed rhizomatic framework operationalizes integrated practice by entangling technical, ethical-interpretive, and relational-connective moves in non-linear clinical reasoning, illustrated through a longitudinal case.

Conclusion: Deliberately cultivating ethical-interpretive and relational-connective capacities, alongside technical expertise, prepares physicians to navigate complexity, orchestrate interprofessional teams, and critically collaborate with AI while keeping the person—rather than the problem—at the center of care.

Keywords: Hidden Curriculum; Professional Identity Formation; Narrative Medicine; Clinical Reasoning; Interprofessional Education; Artificial Intelligence; Medical Education; Biomedical Training

Introduction

The Crisis of Disconnection in Modern Medicine A man with shortness of breath sits through a five-minute consultation, eyes darting between an EMR template and a clinician who never leaves the keyboard. Labs populate, a guideline fires, orders are placed, and the visit ends without naming his fear that the breathlessness is grief and debt as much as physiology. In the next room, a colleague meets a similar patient but proceeds differently: she listens first, narrates uncertainty, maps medication risk against the patient's caregiving responsibilities, and coordinates with a social worker for housing support. Both clinicians know the science, but only one allows the story to reshape the plan. The difference is not knowledge; it is how that knowledge is braided with ethics and relationship within the institutional choreography of care (Charon, et al. [1,2]). Medical education still encodes a "hidden curriculum" that privileges dispassion and reductionism, training students to prize certainty, speed, and detachment as proxies for competence (Hafferty, et al. [3,4]) PubMed; PubMed. Historically, this ethos traces to Flexnerian scientific standards and the clinical gaze that objectified the body—powerful reforms that also narrowed medicine's phenomenology of suffering to what the eye could measure (Flexner, et al. [5,6]) Carnegie Foundation PDF; Monoskop. The cost has become visible: empathy wanes in clinical training, burnout rises under industrial pressures, and patients judge encounters as

impersonal even when technically proficient (Hojat, et al. [7-9]) Academic Medicine; PubMed; Mayo Clinic Proceedings. This disconnection undermines professional identity formation and weakens trust in a time when AI systems surface predictions that demand judgment, context, and responsibility (Cruess, et al. [10,11]).

This Paper Advances a Thesis

Averting the crisis of disconnection requires reconceiving clinical reasoning itself—from a linear, arborized algorithm to a rhizomatic praxis in which technical, ethical-interpretive, and relational-connective moves interpenetrate in real time. After deconstructing the legacy model, we introduce the Rhizomatic Model of Clinical Praxis, then draw implications for pedagogy, assessment, and AI-collaboration. We close by calling for "synaptic physicians" whose integrated practice restores medicine's telos of relieving suffering while leveraging technology without surrendering judgment (Cassell, et al. [12,13]).

Section 1: Deconstructing the Legacy Model:

The Architecture of Dispassion Historical Roots: Cartesian dualism, nineteenth-century pathological anatomy, and early hospital-based clinical teaching forged a gaze that privileged seeing over hearing and lesions over lives. Flexner's report cemented laboratory science and standardization as medicine's backbone—indispensable reforms that also marginalized narrative, moral craft, and the social determinants of health (Flexner, et al. [5,6]) Carnegie Foundation PDF; Monoskop. Rituals of professionalization, such as the white coat ceremony, were designed to encode humanism but also carry hidden signals of hierarchy and detachment in practice (Wear [14]) PubMed. Osler's "Aequanimitas" celebrated imperturbability, a virtue easily misread as emotional distancing rather than steady discernment under uncertainty (Osler [15]).

Hidden Curriculum in Action: The hidden curriculum operates through language that valorizes interesting cases over interested witnessing, role modeling that rewards efficiency over presence, and assessments that punish ambiguity (Hafferty, et al. [3,4]) PubMed; PubMed. OSCEs—celebrated for structure and scalability—too often reduce complex encounters to itemized checklists, reifying an illusion of certainty while neglecting contextual moral labor; validity belongs to use and context, not tests in the abstract (Hodges [16]) PubMed. The result is a pipeline that reliably produces technically capable clinicians who may still struggle to narrate uncertainty, co-create meaning with patients, or steward care across socioecological systems (Epstein & Street, et al. [2,12]).

Limiting Arborism: The legacy model is arboristic: knowledge ascends a trunk of basic science into branching algorithms. This architecture privileges hierarchical pathways and decision trees and leaves little room for the lateral associations through which experience, values, and relationships transform what counts as relevant information (Deleuze & Guattari [17]). Patients present rhizomatically: multiple roots, entangled causes, and emergent meanings. A tree can-

not map a rhizome.

Section 2: The Proposed Framework—A Rhizomatic Model of Clinical Praxis

Philosophical Underpinnings: Deleuze and Guattari's rhizome names a non-hierarchical, acentered, and proliferative network in which any point can connect to any other, assembling the new through transversal linkages rather than linear derivation (Deleuze & Guattari [17]) University of Minnesota Press. Transposed to clinical reasoning, the rhizome enables movement across knowledge, ethics, and relationship without privileging a single path. It counters the clinical gaze's tendency to isolate lesions by re-suturing perception to interpretation and relationship (Foucault, et al. [1,6]).

Three Entangled Dimensions: Technical-scientific (The Knowing). Clinicians mobilize pathophysiology, pharmacology, diagnostics, and epidemiology with disciplined rigor. Knowing includes pattern recognition, probabilistic reasoning, and calibration to evidence quality (Epstein & Hundert, et al. [11,13]). Ethical-interpretive (The Being). Clinicians discern values, wrestle with trade-offs, and situate decisions in patients' moral worlds. This is the texture of professional identity: learning to think, feel, and act like a physician with integrity (Cassell, et al. [10,12,18]). Relational-connective (The Doing). Clinicians collaborate, communicate, and build trust; they work in teams and with communities, recognizing that outcomes are co-produced across professions and systems (Epstein & Street, et al. [2,19,20]).

Narrative Example: The synaptic consultation. A 52-year-old home health aide presents with worsening dyspnea. The clinician resists reflexive algorithm closure. Technical: she interprets BNP and echo data, weighs diuretic dosing, and considers SGLT2 initiation, integrating trial evidence and renal function (Epstein & Hundert [13]). Ethical-interpretive: she weighs side effects against the patient's need to remain alert for night shifts, learns that transportation and copays have sabotaged adherence, and recognizes structural vulnerability. Relational-connective: she co-constructs a plan in the patient's words, arranges pharmacy delivery, and triggers a team huddle with a social worker and pharmacist—while documenting uncertainty for follow-up. The expertise emerges not from any single dimension but from synaptic movement among them, creating a coherent whole in which the person—not the problem—guides the care (Charon [1,19]).

Methods (Conceptual Development): From Training to Cultivation Phase 1: Conceptual grounding and curricular prototypes. We propose mapping existing curricula onto the three rhizomatic dimensions to identify gaps, then developing prototype modules that integrate them: narrative medicine seminars coupled with team-based case conferences; uncertainty-focused OSCE stations; and community-engaged longitudinal simulations (Charon, et al. [1,16,20]). Faculty development will target preceptors' capacity to model interpretive humility and relational skills, aligning with professional identity formation frameworks (Cruess, et al., [10]).

Phase 2

Validation through programmatic assessment. Assessment must reward integration. We will redesign OSCEs to embed ethical dilemmas, sociostructural constraints, and team coordination challenges, judging longitudinal reasoning over checklist completion. Programmatic assessment will combine entrustable professional activities (EPAs), portfolios with reflective writing, and narrative evaluations calibrated to Epstein & Hundert's inclusive competence definition (ten Cate, et al. [13,21]). Validity evidence will be collected at the level of use—across contexts and time—rather than as a property of isolated instruments (Hodges [16]).

Phase 3

Scaling through interprofessional and AI-enabled ecosystems. Implementation requires partnerships across professions and clinical systems. The WHO framework's mechanisms—creating accreditation standards that require IPE and funding interprofessional outcomes—provide levers for scale (WHO [19]). In parallel, we will integrate AI tools as decision support embedded in team workflows, training physicians to orchestrate rather than outsource judgment and to audit algorithms for bias (Rajkomar, et al., [11,22]).

Results (Expected Outcomes and Application): What Integration Makes Possible

Anticipated learning outcomes. We expect measurable gains in learners' ability to articulate uncertainty, align plans with patient values, and coordinate interprofessional resources while maintaining technical accuracy. Portfolios should demonstrate growth in reflective capacity and moral imagination, correlating with entrustment decisions on EPAs involving complex care coordination (ten Cate, et al. [1,21]). Programmatic assessment metrics. Redesigned OSCEs will include longitudinal cases with embedded social risk, requiring learners to revisit and revise decisions. Validity evidence will derive from triangulated sources—observed performance trends, reflective artifacts, and team-based evaluations—linked to supervisor entrustment and patient-reported experience (Hodges, et al. [13,16]). System-level effects. We anticipate improved patient-centered communication scores and team functioning, alongside attenuated empathy decline and more realistic workload-management strategies that address drivers of burnout (Hojat, et al. [7,20]). By shaping identity and practice toward meaning-making and collaboration, the model aims to counteract depersonalization, a core component of burnout (Shanafelt, et al. [8,9]).

Discussion: Significance, Challenges, and the Physician as Orchestrator

Filling the gap. The rhizomatic model directly addresses the hidden curriculum by making interpretive and relational labor visible, deliberate, and assessable. It reframes competence as the habitual and judicious use of knowledge, communication, emotion, values, and reflection in daily practice, aligning the epistemology of training with what care actually requires (Epstein & Hundert [13]) JAMA. It also restores medicine's moral center: the obligation to relieve suffering, which cannot be satisfied by technical prowess alone (Cassell [12]). Pedagogical shift—cultivation, not mere training. Narrative medicine cultivates interpretive acuity; reflective practice builds metacognition; interprofessional education rehearses connective work in teams. Together, these approaches counter the unexamined norms that displace empathy and meaning (Charon, et al. [1,19, 20,23]). Assessment revolution—measuring integration. We should stop pretending that checklists can capture judgment in context. Instead, use longitudinal simulations that entangle ethical tensions and relational barriers, portfolios that curate reflective artifacts and patient narratives, and EPAs that require integrated supervision decisions. Validity evidence must be situated in use: does the assessment support sound decisions about readiness for unsupervised practice across diverse settings? (Hodges, et al. [16,21]). AI collaboration—the physician as orchestrator. AI will amplify pattern recognition and probabilistic triage, but algorithms cannot adjudicate contested values or repair trust.

Physicians must orchestrate: contextualize AI output, detect bias, and center the person. The profession should teach how to critique proxies (e.g., cost as need) and guard equity in deployment (Rajkomar, et al. [11,22,24]) PubMed; PubMed; Science. When clinicians reclaim time for listening by offloading routine technical tasks to AI, empathy is not a luxury; it is the core comparative advantage of human care (Topol [25]). Challenges and responses. Barriers include faculty workload, assessment inertia, and accreditation constraints. The WHO framework suggests system levers: align accreditation with IPE, fund interprofessional outcomes, and explicitly require integrated competencies (WHO, [19]) WHO. Evidence gaps persist for IPE effects on patient outcomes; robust mixed-methods trials and cost-benefit analyses are needed (Reeves, et al. [20]). Cultural change requires reshaping the hidden curriculum through modeling, language, and rituals that encode humility and solidarity rather than hierarchy (Hafferty, et al. [3,10,14]).

Conclusion

The Call for Synaptic Physicians

Reforms that tweak content but preserve arboristic reasoning will not suffice. The hidden curriculum of dispassion must be replaced with a rhizomatic model in which knowing, being, and doing interlock in every encounter. Synaptic physicians move fluidly across the technical, ethical, and relational, orchestrating teams and technologies while holding fast to medicine's first obligation: relieving suffering by honoring persons in their worlds (Cassell, et al. [12,13,19,26]). The path forward is clear: cultivate narrative and reflective capacities, redesign assessments to measure integration, and train physicians to be orchestrators of humane, AI-augmented care. The body is not a machine; the clinic is a rhizome; healing happens at the connections.

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